VERMONT

GROWTH STIMULATING AGENTS - Prior Authorization and Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth	Sex	Medicaid ID #
	M ☐ F ☐	

Allergies: ☐ NKA or _____

Street Address	City

State	County	Zip Code

Home Phone	Cell Phone

Parent/Guardian	Day Telephone	Night Telephone

Emergency Contact	Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number

Telephone Number	Fax Number	Hospital/Clinic Name

Street Address	City

State	County	Zip Code

Contact Person at Office	Prescriber Specialty

icore PHARMACY SERVICES

MedMetrics HealthPartners

Fax Completed Form to:

Fax Number: 866-364-2673

Phone Number: 800-327-1392

3 Office of Vermont Health Access
GROWTH STIMULATING AGENTS
PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

Requested OVHA **PREFERRED** Growth Stimulating Agent

☐ Norditropin® ☐ Nutropin® ☐ Nutropin® AQ

Growth Hormone Stimulation Test # 1	Test:	result:
Growth Hormone Stimulation Test # 2	Test:	result:
Patient's Height:		
Patient's Bone Age:		
Patient's Chronological Age:		
Growth Velocity:		
IGF-1 results:		

Please explain the medical necessity for a '**NON-PREFERRED**' product:

☐ Genotropin® ☐ Humatrope® ☐ Omnitrope® ☐ Saizen® ☐ Tev-Tropin®

Medical justification: _____

_____

Request is for a '**SPECIALIZED INDICATION**' product: (Criteria in Clinical Criteria Manual)

☐ Increlex® ☐ Serostim® ☐ Zorbtive®

Other information/ Prescriber comments:

4 PRESCRIPTION

☐ Norditropin® Nordiflex ☐ Norditropin® Cartridge ☐ Nutropin® ☐ Nutropin® AQ

☐ Other Product: (Please Specify) _____

Dosage Form / Strength: _____

Dose/Route & Frequency (Sig):_____

Dispense Quantity: ☐ One month supply or _____ Refill X _____

☐ Needles/syringes: quantity sufficient for drug supply with refills as above

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

Prescriber's Signature: _____ **Date:** _____

Last Updated 10/2008